

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
Quality Assurance Division
LICENSE APPLICATION and REAPPLICATION FOR YOUTH CARE FACILITIES

☐ NEW APPLICANT

☐ RENEWAL APPLICANT

NAME OF CORPORATION OR AGENCY: _____

NAME OF HOME/FACILITY: _____

CORPORATION MAILING ADDRESS: _____ CITY _____ ZIP CODE _____

RESIDENTIAL ADDRESS: _____ CITY _____ ZIP CODE _____

CORPORATION/AGENCY TELEPHONE: _____ HOME/FACILITY TELEPHONE: _____

NAME OF EXECUTIVE DIRECTOR: _____

NAME OF PROGRAM DIRECTOR: _____

NAME OF PROGRAM MANAGER: _____

FACILITY CONTACT E-MAIL ADDRESS: _____

Type of Home or Agency to be licensed. Please check each that applies.

☐ Youth Group Home No. of Beds: No. of Bedrooms:

☐ Therapeutic Youth Group Home No. of Beds: No. of Bedrooms:

☐ Youth Shelter Care No. of Beds: No. of Bedrooms:

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| <input type="checkbox"/> Child Care Agency | No. of Beds: <table border="1" style="width: 150px; height: 40px; border-collapse: collapse;"><tr><td style="height: 20px;"></td></tr><tr><td style="height: 20px;"></td></tr></table> | | | No. of Bedrooms: <table border="1" style="width: 150px; height: 40px; border-collapse: collapse;"><tr><td style="height: 20px;"></td></tr><tr><td style="height: 20px;"></td></tr></table> | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

☐ Maternity Home No. of Beds: No. of Bedrooms:

Age Range of youth to be served: Total number of youth to be served:

Number of Males: Number of Females:

Pursuant to HB 66, the QAD Licensure Bureau estimates that your application for license or license renewal will be processed within 60 days of the Division's receipt of ALL application materials.

PROVIDER: PLEASE CHECK "✓" IF ITEM IS ENCLOSED WITH THIS APPLICATION OR WRITE IN THE DATE WHEN THE ITEM HAS BEEN OR WILL BE SENT TO THE DEPARTMENT.

| Date or | ✓ New Applicant | Date or | ✓ Renewal Applicant |
|---------|---|---------|---|
| _____ | <input type="checkbox"/> Articles of Incorporation, Bylaws or Letter from Sponsoring Board | _____ | <input type="checkbox"/> Major changes to Articles of Incorporation or Bylaws |
| _____ | <input type="checkbox"/> Organizational Chart | _____ | <input type="checkbox"/> Organizational Chart |
| _____ | <input type="checkbox"/> Current list of Board of Directors including terms of office and addresses | _____ | <input type="checkbox"/> Major changes to program or Personnel policy |
| _____ | <input type="checkbox"/> Plan for Orientation/training of Staff | _____ | <input type="checkbox"/> Current list of Board of Directors including terms of office and addresses |
| _____ | <input type="checkbox"/> Grievance procedures staff | _____ | <input type="checkbox"/> Personal Statement of Health CRL-005 (one for each staff member) |
| _____ | <input type="checkbox"/> W-9 Taxpayer Identification Form | _____ | <input type="checkbox"/> Certification from Fire Marshal Pursuant to ARM 37.97.191 |
| _____ | <input type="checkbox"/> Program Description | _____ | <input type="checkbox"/> Verification of Insurance Pursuant to ARM 37.97.190 |
| _____ | <input type="checkbox"/> Program Policy/Procedures | | |
| _____ | <input type="checkbox"/> Personal Statement of Health CRL-005 (one for each staff member) | | |
| _____ | <input type="checkbox"/> *Certification from Sanitarian | | |
| _____ | <input type="checkbox"/> Certification from Fire Marshal Pursuant to ARM 37.97.191 | | |
| _____ | <input type="checkbox"/> Verification of Insurance Pursuant to ARM 37.97.190 | | |
| _____ | <input type="checkbox"/> Floor Plan/Square Footage report | | |
| _____ | <input type="checkbox"/> Job descriptions | | |

*This is not an Administrative Rule for Youth Care Facilities; however providers are strongly encouraged to obtain this certification to assure an environmentally safe facility.

I certify that all information I have furnished to the Department of Public Health and Human Services is true and correct.

Signature: _____

DATE: _____